Appendix 6

Completed Sample Wisconsin Medicaid Adjustment Request Form

WMAP ADJUSTMENT REQUEST FORM

I. M. Billing — 1. PROVIDER NAME

8 7 6 5 4 3 2 1 — 2. PROVIDER NUMBER

DO NOT WRITE IN THIS SPACE

3. R&S DATE MMDDYY

5. RECIPIENT NAME Recipient, Im A.

2 0 9 8 9 9 1 2 3 5 5 5 5 5 0 — 4. CLAIM NUMBER

1 2 3 4 5 6 7 8 9 0 — 6. RECIPIENT NUMBER

☐ ADD NEW DETAIL(S) TO PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information to be added)

☒ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information as it appears on R&S report)

7. DATE(S) OF SERVICE FROM	TO	8. POS	9. TOS	10. PROCEDURE/ NDC/REVENUE CODE	MOD MOD	11. BILLED AMT	12. UNIT QTY	13. EPSDT FAM PLAN	14. EMG	15. PERFORMING PROVIDER
MMDDYY		1	7	58600	WP	XX.XX	8.0			12345678

16. REASON FOR ADJUSTMENT

☐ RECOUP ENTIRE MA PAYMENT

☐ OTHER INSURANCE PAYMENT $ _____ (OI-P)

☐ COPAY DEDUCTED IN ERROR: ☐ RECIPIENT IN NURSING HOME ☐ COVERED DAYS _____ ☐ EMERGENCY

☐ MEDICARE RECONSIDERATION (EOMB's ATTACHED)

☐ CORRECT DETAIL (In 7-15, enter information as it appears on R&S report. Enter correct information in comment area)

☒ OTHER/COMMENTS:

Please change the quantity from 8.0 units to 9.0 and reprocess for payment.
Thank you.

17. SIGNATURE I M Provider

18. DATE MMDDYY

INSTRUCTIONS: (SEE REVERSE SIDE FOR FURTHER INSTRUCTIONS)

MAIL TO: EDS
8406 BRIDGE ROAD

19. ☐ CLAIM FORM ATTACHED (OPTIONAL)